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TESTIMONY OF SARAH EAGAN, CHILD ADVOCATE FOR THE STATE OF CONNECTICUT, REGARDING THE BUDGET FOR THE DEPARTMENT OF CHILDREN AND FAMILIES
February 27, 2015

Good afternoon, Representative Walker, Senator Bye, Senator Kane, Representative Ziobron, and distinguished members of the committee. I am Sarah Eagan, the Child Advocate for the State of Connecticut and I am submitting this testimony regarding the budget appropriated for Department of Children and Families.

The Office of the Child Advocate responds to citizens' calls for help regarding children, often children with disabilities or those who have been victims of abuse or neglect. OCA reports regarding unexplained and unexpected child fatalities, reviews child-serving systems and partners with stakeholders to develop and implement recommendations for change.

The Office of the Child Advocate recognizes and appreciates the support of the Governor and this Legislature for its collective efforts to maintain the safety net for our most vulnerable children and families during these extremely difficult fiscal times. With regard to DCF's proposed budget, the Office of the Child Advocate would like to highlight the following:

II. There Remains an Urgent Need to Evaluate Children's Well-being and Ensure a Data-driven, Strategic Investment in a Continuum of Mental Health Support.

Over the last four years, DCF has significantly decreased the state's use of congregate care (both group homes and residential facilities) for children and youth with significant mental health needs and children involved with the child welfare system. DCF's effort to support more children in family-based care is consistent with the laudable goal of reducing unnecessary reliance on institutional care. All children need close connection with consistent, nurturing caregivers and should reside in the least restrictive environments. Additionally, DCF has made progress in placing abused and neglected children who are removed from their parents in family/kin foster care.

Though DCF's expenditures on congregate care continue to decrease, community-based supports remain inadequate.

The dramatic downsizing in congregate care requires that the state have a continuum of prevention, early intervention and treatment services necessary to meet the needs of children now placed in families. We still have significant gaps in access and availability to evidence-based services, skilled care coordination, culturally and linguistically competent services, short term stabilization and assessment services, substance abuse treatment, and early childhood and developmental health supports—as well as the ability to ensure appropriate matching between a child and families' needs and the programming offered.

The Department submitted a comprehensive blueprint for this reform work in October, 2014, and OCA is encouraged by this important work. Yet a profound need remains for mental health system building.

As the state reduces use of congregate care, some children with complex mental health needs still require stabilization, assessment and brief strategic treatment that can only be provided in a setting that is expected to provide round-the-clock skilled support staff. Such settings must be part of a continuum of community supports that can ensure continuity of clinical care for children and ongoing engagement with families.

OCA hears frequent concerns from community providers and health care practitioners regarding the lack of capacity in our current mental health continuum for children in and out of DCF care.

OCA also hears concerns from providers regarding the instability of children placed in the community, who may, as a result of this instability, move through emergency settings, incurring more loss and trauma along the way.

The state is still working to develop a comprehensive, regionalized needs-assessment to support strategic investment in the types of connected, continuous supports that children need. DCF is coordinating the state's efforts to reform and strengthen the children's mental health services delivery system.

While some monies saved from the reduction in congregate care have already been invested in community-based supports, in his most recent report, the federal court monitor overseeing DCF strongly cautioned that the state has not adequately reinvested these savings and that significant service gaps continue to jeopardize children's welfare. (Report of the Juan F. Court Monitor, hereinafter "Juan F.", 3rd quarter report, 2014, pg. 4).

The monitor recently reported that the lack of funding for community supports "is harmful to the thousands of children that have been and continue to be diverted" from congregate care. (Juan F., pg. 4.)

Service gaps identified by the federal court monitor's office in its most recent report include:

- lack of sufficient out-patient services for children and adults,
- in-home services,
- substance abuse services,

- re-unification services,
- domestic violence services,
- emergency psychiatric services,
- support services for both non-related and
- Related family resources and the need for additional foster home resources."

(Id.)

As DCF works with its partners on next steps in the implementation of the state's new mental health plan for children, it will be imperative to set a timetable for strategic investment in community-based supports as outlined by the federal court monitor and other stakeholders.

Services for Our Most Vulnerable Children: Infants and Toddlers

It will be essential for DCF, and its partners across state agencies, to strategically invest in evidence-based services for high-risk families with infants and toddlers, particularly those at risk of or who have already been substantiated victims of abuse or neglect.

OCA published a report on July 31, 2014 regarding the preventable deaths of infants and toddlers in the state during the previous year. Of the 38 children, age birth to three, who died from non-natural causes:

- 9 children had open cases with DCF at the time of their death;

- 9 more children lived in families whose DCF case closed within the previous 6 or 12 months.

- Deaths were due to unsafe sleeping conditions (children are at heightened risk of these deaths when sleeping with a parent who is substance using), accidental causes, and child abuse.

- Emerging data regarding 2014 infant-toddler fatalities is similar to 2013.

DCF currently invests in evidence-based supports such as Child FIRST, and promising practices such as Family Based Recovery--clinical services for high risk families with very young children.

But the state currently lacks capacity to ensure that all high-risk families with very young children receive the supports that they need.

Investment in a continuum of home visitation services, with special attention to clinical, trauma-informed two-generational programs, will be critical to support better outcomes for high need infants and reduce preventable child deaths. Investments should be made in *evidence-based services,* and outcomes should be reported and dis-aggregated for age of the child.

Quality Assurance: Measuring Children's Wellbeing and Needs Met

There remains an urgent need to *collectively* review 1) how well children with complex behavioral health needs are being served in the community and 2) where additional strategic investments must be made to ensure an appropriate continuum of supports for vulnerable children and youth, and their families.

While surely many children have successfully transitioned to family placements, much work remains to measure the **quality of care** for children with mental health needs who have transitioned to community settings from congregate care. **A qualitative analysis of children's well-being after such moves is missing from our current discussion about this important topic.**

DCF has implemented many promising new initiatives, from Differential Response System (also known as Family Assessment Response), to team decision-making for children in care, and these initiatives stem from evidence-based practices around the country designed to improve family engagement and increase permanency and stability for children.

OCA agrees with the federal court monitor that these initiatives are promising and important developments for DCF and the children of the state.

> ***But it is imperative that new initiatives are implemented with corresponding investment in community-based supports, and comprehensive quality assurance protocols to ensure that children are better off and well-served.**

It is also imperative that DCF-operated facilities, including Solnit North and Solnit South (formerly known as Riverview Hospital and Connecticut Children's Place be able to report on the effectiveness of service delivery for children, including clinical outcomes for children and youth served.

DCF-operated facilities cost tens of millions of dollars each year to run. Policy-makers have often discussed the merits of these investments and whether these facilities are achieving desired outcomes for children and youth. Given the cost of these programs to the state, it is essential that policy makers have information regarding the quality and effectiveness of all state-operated facilities.

II. OCA does not support moving juvenile justice functions of Court Support Services Division to DCF.

Right now Connecticut Court Support Services Division of the State Judicial Branch is responsible for the vast majority of juvenile justice programming for children, including juvenile detention and community-based diversion and service programs. CSSD has successfully implemented various strategies to divert children from the juvenile justice system whenever appropriate and has a comprehensive and sophisticated continuous quality improvement framework.

Currently, DCF is responsible for the youth that may need out-of-home placement and incarceration, a very small percentage of all juvenile justice youth in the state.

While DCF is implementing new reforms in juvenile justice quality assurance and programming, much work remains to ensure that DCF's practices and services are consistent with national standards and best practices.

OCA continues to see urgent need for improvement, particularly regarding conditions of confinement for juvenile justice-committed youth in DCF custody, and for continuous quality improvement and reporting regarding all DCF-operated facilities.

In 2014 OCA re-opened an investigation into conditions of confinement at the Connecticut Juvenile Training School and Pueblo Girls' Program, in part due to a number of citizen complaints that had been registered with this Office. OCA subsequently conveyed the following concerns to DCF:

- Over-reliance on restraint and restrictive sanctions to manage children and youth, including lengthy seclusions, physical and mechanical restraints and handcuffs for girls and boys.
- Lack of appropriate trauma-informed interventions for youth entering the facility with known and extensive histories of abuse, neglect, trauma and complex mental health disorders.
- Over a dozen examples of suicidal behavior in the girls' and boys' facilities collectively over the last 8 months.
- Arrest of girls' and boys' in these facilities for conduct that may arise out of their mental health disorders.
- Unreliable framework for measuring and reporting regarding conditions of confinement.

A reliance on restrictive measures is particularly concerning in any child-serving program given the prevalence of mental health disorders in confined children and the advisement from experts that seclusion and restraint are particularly damaging, and re-traumatizing, for children and adolescents.

***Any state-funded, child-serving facility or program, whether a therapeutic or juvenile justice program, must be able to evaluate and report how well it is addressing youths' need for assessment, stabilization, treatment, rehabilitation, education and discharge to community care.

DCF has taken some steps in recent months with the goal of improving conditions for youth at CJTS and Pueblo. The Department has recently contracted with a clinical consultant to evaluate the facilities, sent some staff to training regarding techniques to reduce restraint and seclusion, and the Department is collaborating with the University of New Haven Youth Justice Institute to examine conditions of confinement at CJTS and Pueblo.

These are positive steps that will hopefully improve support for youth and staff in these facilities moving forward.

However, given the breadth of OCA's concerns, OCA cannot at this time support transition of responsibility for the state's juvenile justice population to the Department of Children and Families.

Thank you for your time and attention.

Sincerely,
Sarah Healy Eagan, JD, Child Advocate, State of Connecticut